worked in banking, cash management, payments, check claims, and government-wide accounting.

In recent years, he has worked under the Fiscal Assistant Secretary, serving as an adviser to senior department officials. His intellect and diligence have been critical as the Treasury addresses economic recovery.

Earlier this year, Kenneth helped direct the Treasury's implementation of its responsibilities under the American Recovery and Reinvestment Act. He led the development of two new departmental programs aimed at spurring economic growth. One of them helps renovate affordable housing for struggling families, and the other funds renewable energy initiatives.

Kenneth has also earned respect as a leader in cash-and-debt management infrastructure. Americans who use a national debit card to receive their Social Security benefits have him to thank for leading the implementation of this program.

His hand has helped shape how the Treasury deals with debt financing, trust fund administration, cash management, and a range of services.

Kenneth Carfine and all of the hard-working employees of the Treasury Department are leading the way toward economic recovery and sound fiscal management of the taxpayer's money. I hope my colleagues will join me in thanking them all for their service to our Nation.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. MERKLEY). The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. SHAHEEN). Without objection, it is so ordered.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent to speak as in morning business for up to 20 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. WHITEHOUSE. Madam President, I have spoken many times on this floor about the urgency of the need to reform our broken health care system, to expand access to insurance, to improve below average results, and to bring down costs. In a speech to the joint session of Congress, the President eloquently described the challenge of this moment:

> I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge—in some way. . . . Our collective failure to meet this challenge—year after year, decade after decade—has led us to the breaking point.

We are at the breaking point for Nancy from Barrington, RI, a single mother and accomplished music teacher who lost her full-time job and currently teaches part time at a local university. Nancy has paid the full cost of health insurance out of pocket so her two children would not go without coverage. But now they have graduated from college, they are no longer eligible to be on her insurance policy, and they work at jobs that don't provide health care benefits. So Nancy is now thinking about selling her home, their childhood home, to prevent her family from going without health insurance. Nancy writes:

> Between the three of us, we are desperate for a workable solution to our health insurance needs. For the first time in my life I feel utterly disenfranchised by my own society.

We are at the breaking point, not just for Nancy but for so many Rhode Islanders who have shared with me their stories—stories of loss, stories of sorrow, stories of frustration, stories of personal and family disasters, in a treacherous health care system that offers all the care you need until you need it.

We are also at the breaking point nationally. Our country's economic future may well depend on the reforms and investments we now craft to control costs and wring savings from the system.

One measure of the potential savings is the recent report of President Obama's Council on Economic Advisers, comparing the share of America's gross domestic product spent on health care to the share spent by our industrialized international competitors, and evaluating the wide variation in health care expenses region to region within the United States.

The report estimates annual excess health care expenditures of about 5 percent of GDP. That translates to over $700 billion a year in excess cost. They are not alone. The New England Health Care Institute reports that as much as $850 billion in excess costs every year ''can be eliminated without reducing the quality of care.'' That is $850 billion.

Former Treasury Secretary O'Neill, the Treasury Secretary in the Bush administration, has written recently that the excess cost in our health care system is $1 trillion a year. The Lewin Group, a consulting firm that is well regarded on health care issues, has estimated that excess cost exceeds $1 trillion per year. So is it $700 billion a year? Is it $850 billion a year? Is it $1 trillion a year? Whatever it is, it is a savings target worth an enormous executive and legislative effort, particularly when the evidence is that achieving these savings will actually improve health care for the American people.

Where will these savings come from? Well, the savings await us in quality of care. For instance, the Keystone Project in Michigan reduced infections, respiratory complications, and other medical errors in some of Michigan's intensive care units between March 2004 and June 2005, a little over a year. The project saved 1,578 lives, 8,120 days that patients otherwise would have spent in the hospital but did not have to because they did not get the infections or the complications and, as a result, over 165 million health care dollars, just in Michigan, just in intensive care units, just in 1 year, and not all of the intensive care units.

In my home State, the Rhode Island Quality Institute has taken this model statewide with every hospital participating. We are already seeing hospital-acquired infections and costs declining. There is a similar opportunity in disease prevention. The Trust for America's Health found that investing $10 per person per year in programs that increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion annually within 5 years.

Out of that $16 billion in savings, Medicare would save more than $5 billion, Medicaid would save more than $1.9 billion, and private payers would save more than $9 billion. So that is quality of care and prevention.

A third area for significant efficiencies and savings is the insurance industry's contentious, inefficient billing and approval process. The battle over approvals for treatment and claims for payment creates a colossal burden on our health care system, causing perhaps 10 to 15 percent of the insurance industry's expenditures because the hospitals and the doctors and the providers have to fight back. That 10 to 15 percent of the insurance companies' expenditures casts a cost shadow over the provider community which is probably bigger than the insurance industry spends, because they are less efficient at fighting back than the insurance company is at tormenting them.

It all adds no health care value. None. It is pure administrative costs and cost shifting. Rhode Island providers have told me over and over that half of their personnel are absorbed in this battle and not providing health care. They are at the doctor's office, they work there, but they are not providing health care. They are busy fighting with the insurance company.

Even the insurance industry estimates that $30 billion per year could be saved through simplifications of the process. That relates to a fourth area, the overall inefficiency and waste that plagues the private insurance market.

While administrative costs for Medicare run about 3 to 5 percent, overhead for private insurers is an astounding 20 to 27 percent. A Commonwealth Fund report indicates that private insurer administrative costs have more than doubled in the past 6 years. From 2000 to 2006, they increased 109 percent.

The McKinsey Global Institute estimates that Americans spend roughly

$128 billion annually—$128 billion annually—on excess administrative overhead in the private health insurance market.

A fifth savings area is investments in our infrastructure of health information technology; secure electronic health records, for instance, electronic coordination between your doctor and your specialist and your pharmacy and your hospital and your laboratory. These investments promise big savings as well, $162 billion per year, according to one RAND study, and possibly twice that.

Finally, reform of how we pay for health care will yield enormous dividends. At the moment we mostly pay on a piecework basis. The more you do, the more you are paid. No surprise that we do a lot and pay a lot. Since the best care, the best quality care is so often less intrusive but better designed and better coordinated, this payment reform presents another win-win opportunity: better health care and lower cost, hand in hand.

There is a problem, though. For many of these reforms, CBO cannot fully score the savings they would yield, and thus their importance has been minimized in our debate. CBO can only estimate health care costs and savings that have historic precedent. For example, on the cost side we have the experience of Medicaid, and the Children's Health Insurance Program. So CBO can estimate how much it will cost to expand the coverage to needy families, as we importantly do in this bill.

On the savings side, however, CBO's capability is limited because there is not a lot of information to forecast from. CBO's Director has been refreshingly candid about this. In a recent letter to Senator CONRAD, he wrote the following:

> . . . changes in government policy have the potential to yield large reductions in both federal health expenditures and federal health care spending without harming health. Moreover, many experts agree on some general directions in which the government's health policies should move, typically involving changes in the information and incentives that doctors and patients have when making decisions about health care . . . Yet, many of the specific changes that might ultimately prove most important cannot be foreseen today and could be developed only over time through experimentation and learning.

So to summarize: Large reductions in costs are possible. The general direction in which to move to achieve them is agreed. But experimentation and learning are necessary to get there.

Even with those analytical limitations, CBO has recognized some cost savings created by several innovative reforms in the Finance Committee's bill. For example, CBO forecasts that an independent nonpartisan commission of experts with authority to determine provider payment rates under Medicare will save the Treasury $22 billion over a 10-year period.

It also credits Medicare payment reforms that seek to prevent hospital readmissions with $2.1 billion in savings; incentives that encourage physicians to group together in cost savings organizations with $4.9 billion in savings, and payment reforms aimed at preventing health care-acquired infections with $1.5 billion in savings.

But as you have seen, in comparison to the numbers I talked about earlier, those are trivial projections, chump change against the excess cost of our health care system. Americans owe the Congressional Budget Office a particular debt of gratitude for how incredibly hard they have worked these past weeks and months. CBO performs a valuable service.

But its professional discipline requires it to score legislation basing its calculations on what it can chronicle has happened in the past. And we have not yet been where we need to go in health care reform. Moreover, getting there will require leadership, creativity, and perseverance in executive administration, with constant adjustments and improvements along the way to achieve our goal.

Those factors of executive administration are beyond the capability of CBO to predict. The distinguished Presiding Officer was the Governor of the State of New Hampshire. She knows well, having served as Governor, what a difference executive administration can make in areas where there is intelligent and sustained focus. Well, CBO cannot predict whether intelligent and sustained focus will occur, so they cannot predict the answer to that question.

Let me mention one further reform now that we are on the subject of executive administration, a final reform that can bring leadership and creativity toward achieving all of these goals in quality, in prevention, in payment reform, and in information technology. That is the reform that can bring leadership and creativity to pulling all of those reforms together, a public health insurance option, a government-run publicly handled plan that can provide affordable coverage in a market where premiums have increased 128 percent in 8 years.

A public option can bring vigorous competition to a market so monopolistic it would make Andrew Carnegie blush, will force private plans to minimize bloated administrative costs which have increased, as I said, 109 percent over those 6 years. The public option can pass along savings to consumers in the form of reduced premiums, and can end the wasteful practice of fighting with doctors and patients over reimbursement.

The public option is our best chance for executive implementation of the delivery system innovations and reforms I have described. Skillful executive administration will be required just as for every other element of reform. But public plans across the country, driven not by private motives but by the public good, set new standards of quality and efficiency in a market that has lost its way.

The point of this reform must be to turn around a health care system that is now spiraling out of control. We spend 18 percent of our GDP on health care. The next highest spending nation in the world is Switzerland at 11 percent. Even if our success is limited to shaving a few percentage points off our national expenditure on health care, that success will be worth hundreds of billions of dollars a year. Yes, there will need to be an initial investment in health care reform, but the potential savings are multiples larger.

CBO's inability to score these savings does not mean they aren't real and achievable. Given the looming threat to America's fiscal security that is now presented by our health care costs, these savings are not only real and achievable, they are essential. They are necessary. We are bound to achieving them, and we must not fail. For that reason, I call on the Obama administration to begin defining a health care savings target from delivery system reform—from health information infrastructure, from quality improvements, from illness prevention, from more transparency and less bureaucracy, from reform of what we pay for in health care and, ideally, all implemented rapidly and fairly by public plans around the country. They need to set a target.

If the administration does not set a savings target, there is no way the vast apparatus of the Federal Government will wheel adequately toward achieving this goal. If we fail to achieve those savings, all our dreams—our dreams of universal coverage, our dreams of affordability, our dreams of a public option—will crumble like castles built on sand.

Let's take the most conservative number from President Obama's own White House, $700 billion a year in annual excess cost. Let's assume the best we can do is to eliminate less than one-third of that excess cost—not all of it, not even half of it, less than one-third. Let's assume it takes a few years to meet that goal; let's say 4 years. That would still permit reform savings of $200 billion a year by 2014. By then, our annual health care expenditures will have climbed well over $3 trillion. So that $200 billion annual savings would be only one-fifteenth, about 7 percent, of the cost, then, of our bloated health care system, a system now costing twice as much as other developed nations' health care systems that cover everyone. That goal, 7 percent off a system that costs twice as much as in other nations, does not seem unreasonable.

I will ask the administration: What is your annual savings target out of that $700 billion to $1 trillion a year in excess cost? What is it, and when will you achieve it? Soon you will have a bill out of this Congress that gives you the tools to achieve these savings.

When you have that bill, I will ask for a number and a date.

I will urge the administration: Be bold. President Kennedy did not know how to get to the Moon when he promised that we would, but he knew we had the talent and the technology to do it, if we had the President's commitment behind it. Sure enough, it happened.

I would also remind the administration of this: We have to achieve these savings anyway. This is not an extra political hurdle the administration would have to clear. This is the bar we must clear if our Nation is to return to fiscal health and if our dreams of universal coverage and affordability and good public health and a humane, efficient health care system are all to be realized. Again, if we don't clear that bar, all those dreams crumble in our hands like dust.

Let's step forward now and make a commitment to some hard, firm measure of savings out of our bloated and inefficient delivery system.

I thank the Chair.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BEGICH). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Mr. President, I ask unanimous consent to speak for up to 15 minutes in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Mr. President, pretty much daily over the last couple of months when the Senate has been in session, I have come to the floor to share letters I have received from people in Findlay, OH—where I was today—Toledo, Sandusky, Mansfield, Lebanon, all over the State. These are letters from people who want to tell me why we need health care reform. These are letters mostly from people I have not met, people who know we need to change some things in this country.

What is interesting is that one of the common themes that run through these letters—in letter after letter after letter—is that people thought they had pretty good health insurance. They were satisfied with their health insurance. If you asked them a year or two ago: Do you have good health insurance, they would have probably said yes. But then they found they had a child who was diagnosed with a preexisting condition, so they were denied insurance, or they got sick and they went above the annual or lifetime cap on costs they did not even know was in their insurance policy, so the insurance company then rescinded them—is the term they use—there was a rescission to eliminate or take away their policy, or they were discriminated against for other reasons, or in many cases they lost their job and lost their insurance.

In case after case, these are people who are mostly middle class, people playing by the rules, paying their taxes, raising their kids, keeping their communities prosperous, and they typically have lost much of what they had.

I want to share some of these letters with my colleagues, particularly colleagues who are not so certain, colleagues who still defend the health insurance system and think we do not need significant change, so that they would maybe understand some of these problems a little better.

The first letter is from Wilkins from Youngstown, which is in northeast Ohio. He writes:

I'm an unemployed former steel worker from Youngstown. I've been struggling to afford my premiums for COBRA while on unemployment and looking for a job.

COBRA is a bit of a cruel hoax. It is a good program for people who can afford it. But COBRA is for when you lose your job that you can keep your insurance if you pay what you are already paying, plus you pay the employer's side of the insurance. That is almost impossible to do for most people who lose their job for a very long period of time. They are only eligible for COBRA for up to 18 months anyway. He writes:

Due to a pre-existing condition of high blood pressure, I had no choice but to continue my coverage under COBRA.

If he had a break in his health care, if he canceled his health insurance and tried to get other less expensive insurance, he would have been denied coverage because of his preexisting condition. He writes:

I'm 59 years old and have been working temporary jobs just to get by, but none offers health insurance. I barely make enough to afford my blood pressure medication.

I've depleted my savings while watching my unemployment insurance run out.

That is something else that this Chamber must consider. I just saw Senator SHAHEEN from New Hampshire a moment ago. She has helped lead the fight on extending unemployment benefits for people whose insurance has run out, something, unfortunately, day after day we have tried to do here, and a Republican Senator has stood up and objected and we have not been able to push that through yet. Unemployment insurance makes so much sense with so many people—from Dayton to Springfield to Chillicothe to Zanesville—who cannot find a job and have seen their unemployment insurance run out.

Wilkins writes:

I'm sick of high insurance premiums. I worked for 38 years and now I have no health care coverage.

They threw me away like an old shoe. It's me today and it could be anyone tomorrow.

I may not have three years to live until I receive Medicare if I can't afford my medicine.

I need health reform now. It just can't wait.

One of the other themes that runs through these letters is that people who are in their late fifties or early sixties and do not have insurance are just praying—praying—they can get enough help and stay well enough, stay healthy enough so they can make it until they are 65 and they can get Medicare.

What does that say? Wilkins from Youngstown worked for 38 years. He lost his job because of what has happened in the steel industry. He cannot afford COBRA. He cannot afford his blood pressure medicine. He is working part-time jobs just to try to get by. He is praying he can get to 65 so he can get health insurance under Medicare—a program that looks a lot like the public option would look if we pass that legislation in the next couple of months.

Robin from Cuyahoga County, in the Cleveland area, writes:

My son just graduated from college and his coverage under his Dad's employer is coming to an end.

While he has found an entry level job, he is not currently a full-time employee and does not have health insurance.

He is incredibly healthy, but when he was in high school he was diagnosed with a heart condition, which could require surgery as he ages, but not for decades [his doctor believes].

As my son was searching for insurance, he was honest about this condition. Each company he called denied him.

So now, a 22-year-old with no history of any illness—

A young man, 4 or 5 years older than the pages who sit in front of us—

but who at some point in the future might need medical support, can't get health insurance.

Instead of creating a system that provides him incentives and proactive monitoring of his condition—

To keep him as healthy as we can—

we have a system that drives him away, doesn't encourage preventive measures, and ends up costing everyone more. I encourage you to take every action possible to put an end to health insurance companies denying coverage for preexisting conditions. We need a system that puts an emphasis on preventive care.

Robin is right about her son. Under our health care bill, as the Presiding Officer from Alaska understands, anyone who chooses to can stay on his mother's or father's health insurance until reaching the age of 26. So her son would have 4 more years on their health care plan under our bill that we are going to debate on this floor in the next few weeks. Robin's son would be able to keep his insurance until he was able, down the line, to get a better job with insurance. Obviously, under our bill, he is going to have access to insurance anyway. But one of the things to help young people as they go into the workforce—maybe they are living at home, just moved out of the house, finishing college or coming home from the military, but so many young people lose insurance because they are working at often low-paying jobs that don't provide insurance for their employees.

Beatrice from Summit County, the Akron area, writes:

As a recent retiree due to economic downsizing, I am left to purchase an expensive insurance plan. But I am not sure how

much longer I will be able to pay for the premiums. I only recently got a temporary contractor job that can end at any time.

After 37 years of employment with the same company, it is sad to think that after all those years, I am unable to afford to pay my insurance premiums and unable to collect my Social Security since I retired early.

As my anxiety and stress increase, additional health problems have surfaced. I am not old enough to qualify for Medicare and unable to afford private insurance or COBRA.

I'm asking for your help in supporting health reform that benefits all Americans.

Beatrice is another example. She has worked for a company—as did Wilkins from Youngstown, who worked for some 30-plus years, 38 years. Beatrice from the Akron area has worked at the same place for 37 years. Both lost their jobs. Both can't afford COBRA. Both can't get insurance. Both are seeing their health compromised.

If you have worked someplace for 30 years and you are in your 50s and you are hoping you can stay alive and stay more or less healthy until you are 65, think of the stress that comes with that; the stress of trying to find insurance; the stress of fighting with insurance companies if you do have a preexisting condition or they put a cap on their coverage and what that does to people's health care. No place in the world, no developed, wealthy nation such as ours puts their citizens through these constant battles with insurance companies, these unending fights when insurance companies do all they can to take coverage away from people who thought they had coverage.

I spoke to the Fendlay Rotary today in a community in northwest Ohio which experienced terrible flooding a couple of years ago and I am working with them to help with the Army Corps of Engineers to get a flood mitigation project put together so these floods don't continue to happen on the Blanchard River. We were talking about the insurance industry.

I don't dislike the insurance industry. I think they do what they have to do because they compete with one another and each does these same business practices. But understand, first, they don't want to cover you if you are not healthy. They would rather not write an insurance policy if you are not healthy, so they hire all kinds of people to make sure they don't take you if you have a preexisting condition or if they think you are going to be an expensive risk. That is on the one hand. Then on the other hand, if you have already been insured by this company, if you already have insurance, they have a whole battery of employees who are there to try to deny coverage. I read the other day that close to 30 percent of claims are initially denied by insurance companies—30 percent. So the insurance industry spends all this money to keep people out who are sick, whom they don't want to insure, to find out if there is any preexisting condition or other reasons not to insure them; and then they hire a whole battery of people to try to deny payment, to deny claims if you have an expensive claim against the insurance company.

Again, no other country in the world does that. A lot of countries rely on private insurance, but they are private not-for-profit insurance companies. They are not companies that try to exclude you from getting coverage, and then if you have coverage and you get really sick, try to cut you off so you don't get your costs paid for, you don't get your claims paid for. It is simply a business model that works for the insurance industry, but it sure doesn't work for the American public. It doesn't work for people who thought they had decent insurance.

The last letter I will read comes from James. James writes:

I've paid all of my life for health insurance and now I can't afford it because I'm unemployed. Because I had no insurance, I've had to go to the emergency room, which cost me over $1,300. I've worked and had health care all my life and now I'm told it could cost me $100 up front to even be seen by a doctor. We need a health care system that works for all of us.

One story, one letter after another. I know when the Presiding Officer is in Fairbanks or Anchorage or anywhere around Alaska, he is hearing the same thing from people, through letters and individual conversations from so many people who thought they had good insurance, only to find out they don't when they get sick; people who are just hanging on until they can get a good government plan, Medicare, when they turn 65; people who have worked hard all of their lives and played by the rules and feel like a discarded old shoe, as the gentleman from Youngstown wrote.

I think about what our health care plan will do and how we are going to change the system and make it work for these four people in Ohio and for hundreds of millions of people around the country, where anyone who is satisfied with their health insurance under our plan will be able to keep it, and at the same time we are going to build consumer protections around those plans. We are going to ban certain practices, including no more preexisting condition exclusions, no more discrimination based on disability and gender and geography and age and race or anything else. No more saying to women, You can't get coverage because you were a victim of domestic violence and that is a preexisting condition. Believe it or not, insurance companies do that sometimes. No more saying to a woman who had a C-section, Sorry, you can't get insurance, that is a preexisting condition because the next baby will have to be a C-Section again and that is too expensive for us.

The second thing the bill will do with consumer protections built around it is it will assist small business, giving incentives to small businesses to cover employees.

Third, this legislation will provide insurance for people who don't have coverage or who are dissatisfied with their coverage.

Fourth, this legislation will provide a public option so that anyone who chooses can go into the public plan, not necessarily go to CIGNA or Aetna or United or Medical Mutual in my State, or one of the private insurance companies. That means when people have the public option, it will keep the insurance industry honest because they won't get away with gaming the system because they have a competitor such as the public option that will compete directly with them. It will mean the public option will help to drive prices down because it will make private insurance more affordable, more efficient. Private insurance companies will no longer be able, because of the competition, to pay $24 million CEO salaries such as Aetna does and so many other private insurance companies do. It will mean that people have more choice in southwest Ohio.

In the Cincinnati-Dayton area, there are two insurance companies that provide 85 percent of the insurance and that is simply not competitive. That is why these monopolistic practices that insurance companies engage in so often run counter to the public interests. That is why the public option is so important: to get people choice, to discipline the insurance companies, to bring in competition, to keep prices down, and it will matter as we move forward.

I thank the Presiding Officer for the time on the Senate floor. This legislation will be debated over the next couple of weeks. We know that 70 percent or two-thirds of the American public want a public option. We know a poll by the Robert Wood Johnson Foundation says more than 70 percent of doctors want a public option. We know an overwhelming number of Democrats of both the Senate and House, 90 percent, support a public option. As I said, almost two-thirds of the public, through consistent polling for the last month, and month after month after month, shows that two-thirds of the public support the public option. It makes sense. It makes a good health care bill that much better. It makes the system work that much better for people who have insurance now and people who don't have insurance, but especially all of us who worry so much about the health care costs in this country and how they have spiraled out of control.

I thank the President and yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS CONSENT AGREEMENT—S. 1776

Mr. BROWN. Mr. President, I ask unanimous consent that the cloture